Group Psychotherapy Methods

SOME POSSIBLE IMPLICATIONS

GROUP PSYCHOTHERAPY METHODS

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FOREWORD

To whom do people take their troubles? This question has been asked in research studies and by the curious. High, if not highest, on any list is the minister in civilian life and the chaplain in military service. Since this has been so for generations and since counseling is more and more being accepted as an integral part of ministering, it is significant that frequent requests come to scientists and clinicians for sharing of research and clinical findings with those who must use them each day.

Chaplain (Major General) Charles I. Carpenter, chief of chaplains, The United States Air Force, was impressed by the reports crossing his desk each month which indicated the number of young persons in the military bringing marriage and family problems to their chaplains. During the summer of 1956 he asked The Hogg Foundation for Mental Hygiene, The University of Texas, to develop intensive one month seminars on Marriage and Family Counseling for thirty chaplains each session. Four of these have been held during the year 1957–1958, with 120 men participating. Consultants from the faculty of The University of Texas, from the Home and Family Life Division, Texas Education Agency, from other agencies with related programs, and civilian ministers and physicians with special training in this field have served as leaders.

Dr. Eugene C. McDanald, Jr., practicing psychiatrist and assistant professor of neuropsychiatry at the Medical Branch of The University of Texas at Galveston, has presented to the seminars, *Group Psychotherapy Methods—Some Possible Implications*. Since these implications have far wider application than for the chaplaincy alone, this presentation is offered for the use of others whose professional work is in groups.

Group psychotherapy, as Dr. McDanald has said, was first devised as a way of meeting the needs of

numbers of military personnel during World War II. Now it is better understood that the group, in itself, is therapeutic in its relationships. First clues of this came from the early social psychologists such as Charles Horton Cooley and E. A. Ross, who began the development of the concept of personality as the social self. These early observational studies have been carried forward under rigid research design by present day psychologists and sociologists. Psychiatrists have come to see the healing of the emotionally damaged self as possible in group situations, even as the development of personality is now understood as a group process.

Dr. McDanald writes, "The religious leader, the educator or group worker who cares for and shares with those in the groups where he works, and who, in addition, has an expert appreciation of what is being communicated to him by means of verbal or nonverbal signals, can give answer in large measure to the basic need of persons: their need to be meaningful emotional and spiritual entities in their own estimation and in relationship to their fellowman."

The chaplains of the Marriage and Family Counseling Seminars for The United States Air Force take pleasure in sharing their new insights into the meaning of group experiences through this pamphlet.

BERNICE MILBURN MOORE

GROUP PSYCHOTHERAPY METHODS

Some Possible Implications

BY EUGENE C. McDANALD, JR., M.D.

Persons who experience difficulties in living are numerous in our day and culture. Many of them come to various kinds of counselors—ministers, social workers, clinical psychologists, educators, personnel managers, as well as psychiatrists. Group psychotherapy, a developing method of treatment, offers possibilities for meeting the increasing needs.

About 16 years ago, a University teacher remarked that graduates from a certain school were, on the whole, perhaps more competent in technical knowledge and skill than graduates with similar training from certain other institutions. He went on to lament, however, that these technically superior graduates lacked the skills in getting along with people that the technically inferior graduates from the other schools possessed. Such a statement makes one wonder if many of our schools are not devoted primarily to turning out technically able graduates, since 75 per cent of the persons dismissed from their positions in trade, industry, and technical occupations are dismissed, not for inefficiency, but for personality difficulties.[1] This rather staggering fact suggests that a large number of people in our society are ill-prepared for working and living in groups in spite of their technical proficiency.

Many people with personal and interpersonal difficulties need specialized help. Before the last war, individual psychotherapy, by itself, or in conjunc-

tion with physical treatment, was one of the principal methods of helping people to check, ameliorate, or correct a state of emotional imbalance. Before World War II, group therapy had been used by civilian psychiatrists to a slight extent in the United States and England, but during and after the war, it became an important mode of treatment. When group therapy was first used by the armed forces on a large scale, it was rationalized that the shortage of psychiatrists to do the needed therapeutic work with the individual war casualties warranted its use. Since the defeat of Germany and Japan, various types of group therapy have become the means of treating an increasing number of civilian patients both in and out of institutions, and some research has been done to understand the dynamics of the group process. Now, persons who have done both individual and group psychotherapy recognize that group therapy is no longer a mode of treatment requiring arbitrary justification, but a mode of treatment with its own theory and methods. The group itself helps the participants to useful insights, thereby making for healthier interpersonal functioning in daily living.

Group Methods

At this point, let us note the group methods which have been used with some success. Aside from the therapeutic social club, which will not be discussed here, there are four general methods for conducting group therapy. Two of these, the repressive-inspirational and the lecture-discussion forms, are leader dominated, the leader usually being the therapist who attempts to increase the health in the group by developing its *esprit de corps* through some form of encouragement, intellectual stimulation, or common group interest. These two methods have been found useful in building group morale in war casualties, hospitalized psychotics, neurotics, patients formerly hospitalized, and alcoholics.

The two other methods, psychodrama and analytically oriented group psychotherapy, focus

mainly on individual patients in their interactions with each other and with the therapist who functions as a participant-observer. Instead of covering over individual emotional or behavior problems by intellectual discussions which emanate from a leader, persons in these types of groups come to grips with their specific problems and try to understand them from a genetic-dynamic or purely dynamic point of view. The types of personality problems responsive to these two methods will be discussed in connection with the description of the methods.

Repressive-Inspirational[2]

Repressive-inspirational group therapy, as previously mentioned, was used in treating military personnel during World War II. The therapist made no effort to get the patient to reveal more than he could comfortably volunteer about the cause of his anxiety that led to his breakdown. As a matter of fact, the causes of his personal anxiety were explained away, insofar as possible, by statements to the effect that everyone was more or less homesick; that the normal person was afraid when subjected to active or passive conditions of combat stress; that each person had his breaking point. Emphasis was placed on the possibility that many who suffered from combat and other types of emotional exhaustion could still participate in the war effort in some capacity other than the one they were engaged in at the time of their breakdown. Importance was also placed on the ideal that each person in time of war makes more in the way of effort and sacrifice than he might be comfortable in doing, and that the extra effort and sacrifice were contributory to the preservation of our way of life. Many men with basically normal personality structures responded to the repressive-inspirational form of group psychotherapy in conjunction with rest, nourishment, and recreational and occupational therapy, and they elected, after a short period of time, to return to their parent organizations. Others knew they

would not hold up if they returned to the stress that precipitated their emotional decompensation and, quite wisely, chose reassignment to units removed from the areas of stress.

Lecture-Discussion[3]

The lecture-discussion approach was also used during the war. Lectures usually consisted of an intellectual presentation of situations and attitudes which precipitate emotional illness, and the discussion centered about what one might do on a conscious level to adapt to difficult situations and to correct unhealthy attitudes.

In short, an effort was made during the war by way of repressive-inspirational and lecture-discussion techniques to help the person who had lost his capacity to adapt to stressful situations feel not only that he had done the best he could, but that he was still capable of doing a job, in a less intense situation, with his basic resources reinforced by minor or major changes in his conscious attitudes.

The repressive-inspirational and lecture-discussion techniques are currently utilized not only by psychiatrists, but also by mental hygienists, physicians, social workers, clergymen, Y.M.C.A. and boy scout officials, and many others who give talks to and hold discussions with groups on topics such as mental health, emotional development, psychosexual growth and attitudes, and the function of religion in daily living. These methods are useful to the extent that they provide the elements of support, reassurance, education, and inspiration to make life more meaningful and less anxiogenic.

Psychodrama[4]

Psychodrama, the third group method for discussion, has as its thesis the idea that spontaneity is a prerequisite to normal adaptability. The corollary to this is that the individual who is inflexible and stereotyped is apt to possess rigid points of view which lead to an abnormal adaptation. Psychodrama attempts to correct this by providing a the-

atrical setting in which greater spontaneity can be achieved through role playing by one or more patients in the presence of a director-therapist and an audience. The director-therapist may define what role or roles each patient may play, and, in addition, may himself assume a definite dramatic, catalytic, or interpretive role in the group drama; or, he may withdraw to the audience. The most important feature of the drama is that it must be spontaneous.

There is much that is not understood about the specific features of psychodrama, but, as a whole, it provides a role playing opportunity for exposing pathological behavior and for learning new and more appropriate forms of social behavior. Persons who have been found to benefit, to date, include schizophrenics, neurotic children and adults, the mentally retarded, delinquents, and those with marital problems. The psychodramatic approach varies with the problems that are presented, but once the patients become absorbed in their acting, they proceed from their assigned roles to a more or less free-wheeling expression of their personal difficulties in living. In the process of role playing, the patient apparently derives great benefit from expressing his feelings in the life-like drama and in cultivating roles which allow him to handle more adequately his problems in interpersonal relating. Role playing, in enabling patients to see their problems from a personal, as well as from an extra-personal point of view, becomes a controlled learning situation that can contribute significantly to emotional and social development.

Analytically Oriented Psychotherapy[5]

Analytically oriented group psychotherapy for neurotics goes a step further than psychodrama by putting the premium on spontaneous individual participation in the context of a group whose purpose is to provide members with an opportunity to study their healthy and unhealthy ways of relating to others.

Discussion of analytically oriented group psycho-

therapy for outpatients will include material on the personal and interpersonal factors considered in the setting up of a group, the size of the group, the physical setting for the meeting, the average duration and frequency of the meetings, the characteristics of the therapist which promote group work, the facilitation of the group therapist's work by an observer, the three phases of a group's life history, and finally, something about the advantages of group methods.

Setting Up a Group

Patients who are invited to join a group have usually been in individual psychotherapy for a varying amount of time. The therapist, prior to selecting any individual for group work, has made some assessment of each patient's problems in the context of his life history. The therapist, in addition, has assessed his relationship with the patient and feels he can be sufficiently supportive to enable the patient to endure the initial period of anxiety that occurs in the patient's meeting with and revealing himself to a group of strangers. The therapist may include in the group patients whose insecurity is expressed in moderately severe disruptive or destructive tendencies, but to offset this, he, of necessity, must see to it that the majority of the patients reflect a balance of constructive individual personality forces in order to insure the operational integrity of the group as a whole.

It is not wise to put patients into a group, regardless of their apparent fitness for group work, unless they are willing to experience the group situation. It is also unwise for a therapist to attempt group work if he is overly apprehensive about experiencing the group process. Hence, as a general principle in composing groups, the therapist should select those individuals who, he feels, will contribute with him toward the development of a "we" feeling. The less anxiety in the therapist, or, to put it in another way, the greater the self-esteem or security of the

therapist, the greater can be the insecurity of the individuals chosen to compose the group.

In the establishment of a group, there are therapists who advocate that patients who are overtly homosexual, sadistic, alcoholic, markedly paranoid or severely obsessive-compulsive, should not be considered for inclusion in groups, because of the anxiety they create in other patients. Some therapists feel that those initially rejected for these reasons may be added later, after the original members of the group have found within themselves the capacity to give each other support. Other therapists do not exclude patients from group psychotherapy because of the nature of their illness, but state that, within limits, factors like similarity of background, common interests, ability to verbalize thoughts and feelings and attitudes, are more important in making for fruitful group interaction than diagnostic criteria. It has proved to be a sound practice to form a group around sub-groups of patients of *two of a kind*, on the principle that one patient may lend support to the other when the going gets rough.

Regarding the sexual makeup of the group, it is felt by some that a group composed of both sexes is best because of its approximation to a real life situation; others feel that the complications are less and the group work is not made less meaningful if the makeup is kept homogeneous.

From what has been said, it is apparent that there is yet to be evolved a complete set of scientific principles relative to the classification or grouping of patients for group work. Dr. Jerome Frank suggests that research in the definition of behavior patterns of patients in group therapy should yield useful data about how patients should be classified or grouped.

Group Size and Meetings

There is general agreement among group therapists about the size of the group. For maximum meaningful interaction, a group of eight to ten seems to be ideal. If one or two are absent, for legitimate or neurotic reasons, there will still be a

sufficient number left for effective interpersonal interaction.

The physical setting for the group meeting is more important than generally thought. This opinion is based on an experience with a group that met, for both therapeutic and social reasons, outside of the clinic situation where the group originated. The group chose Pete's home as a regular meeting site, because Pete's living room was pleasant and had comfortable furniture. The same group would have met where the facilities were less desirable, but comfortable physical arrangements are, no doubt, very helpful in creating an atmosphere in which the group process can begin.

Group meetings usually last one and a half to two hours and are held on the average of once or twice a week.

Therapist's Characteristics

The most important person in the group at the outset is the therapist. To do relatively comfortable group work—no group therapist is absolutely comfortable—he should be at least intellectually aware of what most of his personal anxieties are about. For instance, the therapist may have prestige needs which create no problem for him in individual therapy, because he sees his patients one at a time. He knows that an off-day, which even his patients will recognize, will be balanced by his being his usual effective self eight- or nine-tenths of the time. An additional safety feature is that the patients he sees individually do not have an opportunity to get together to discuss the fact that the spirit did not move him to respond effectively to the material they presented on such and such a day. In group therapy, an off-day for the therapist, especially in the early meetings, may cause him to be anxious about loss of prestige in the eyes of the group. The group may sense the doctor's anxiety and do one of several things: (a) they may ignore the doctor and work on their problems without him; (b) they may subtly indicate his ineffectiveness with a question such as,

"Doc, don't you feel well today?", or comment to the effect that they are not getting anywhere; (c) they may attack him directly and possibly continue the attack after the meeting in the group or subgroup exodus; (d) they may save the attack until the official group meeting is over and meet informally outside the doctor's hearing to discuss the fact that the doctor apparently needs more analysis. If the doctor is aware of his anxiety, and senses that it is getting in the way of the group's progress, he should indicate that the group will have to await his having a better day if they are stymied because of his present inability to be an adequate participant and observer. In this connection, a personal experience will illustrate the point:

A graduate psychology student appealed to me in a group session to help him get over his public speaking anxiety, which he was then experiencing in anticipation of a seminar he was to conduct for the benefit of several hundred psychologists. I told him with some apprehension that if he wanted help from me, he would have to wait until I worked through my own problem of stage-fright. He and the group laughed uproariously, and after a lapse of a few moments, during which I was trying to decide whether they were laughing with me or at me, I decided I had best join them. My reluctant and hard-given honest response occasioned the patient to feel comfortable about his assignment as conductor of the seminar. He told me in a group meeting later, "Doc, I felt if you, as a psychiatrist, hadn't solved your anxiety about speaking in public, I must be in pretty good company." The point I would like to make about this personal illustration is this: if the therapist is anxious, it is well for him to be aware of it, both as a possible source of obstruction to the group work, and as a focal point for a constructive exchange with the patients.

This matter of emotional and intellectual honesty of the therapist is being emphasized because, to borrow from a one-time political weathervane, as the therapist goes, so goes the group. If the therapist hedges on his honesty, patients will hedge on theirs.

In addition to integrity, other assets or characteristics which the therapist should have to make him a more competent leader who cares for and shares with the group include a sound knowledge and a

keen feeling about the psycho-dynamics of health and illness. He should have a friendly and informal manner that eases tension and stimulates expression. He should encourage the emergence of responsibility and leadership in each member of the group. At times he must be protective of the group integrity when one or more members show destructive attitudes toward one or more of the others. This he should do not through restricting expression, but by helping the group as a whole to be curious about the predicament that has developed. He should be aware that the group's verbal and sub-verbal behavior has significance from the standpoint of facilitating or inhibiting the group process. He should let himself be seen by the group as another human being, humble in the knowledge of himself as a person with a special professional background. He must work with the group as both fellow-member and guide, thereby helping it toward its goal of mature interaction in which self-revelation in the group serves to reveal rather than to conceal.

Role of Observer

The work of the therapist can be facilitated by the presence of an observer in the group therapy meeting room. The observer's relative nonparticipation makes for objectivity which can be of assistance to the therapist after the meeting, especially in discussing the interventions and interactions of the therapist and the other group members. Group work necessitates constant self-analysis on the part of the therapist, and the observer can serve an extremely useful function in helping the therapist see his blind spots.

Group's Life History

The point has been made that the therapist is the most important member of the group at the outset of the group work. In the interval between the group's first meeting and the time it reaches maturity as a group, the therapist gradually becomes of lesser importance to the group as a whole. This lessening of importance comes about as a result of

three phases through which a group goes in the course of its evolution to maturity: two phases of self-revelation and one of integration.[6]

In the initial phase of self-revelation the group gets superficially acquainted with itself and in its own way says to each member, "Who are you? What are your problems?" In the second phase of self-revelation, the group says in effect to its constituents, "Well, we know a bit about you and your problems; what we want to know now is, do you see how your problems came about?" In the third phase, that of integration, the group raises a final question, "What are you going to do with what you have learned about yourself?"

Self-Revelation (Phase I)

The most difficult experience of group work for the patient is the definition of his problems in the initial phase of self-revelation. Defining the problem and understanding its interpersonal ramifications—becoming aware of a problem and its consequences—is many times sufficient for effecting a change in one's way of life; at other times, it is necessary that the historical roots of the problem be uncovered before it can be understood and dealt with successfully.

To illustrate the difficulty of defining a problem in a group situation, an example is given here of time-consuming, but fruitful, effort on the part of the group and the therapist with a specific patient.[7] The patient was one who recurrently brought up to the group the difficulties he had in his office, especially with the boss. He knew enough about the phenomenon of transference to know that his hypercritical and inconsiderate boss might be the condensed equivalent of his father and brother in many respects. With the help of the group and the therapist, much feeling was abreacted and certain identifications worked out, resulting in the member's achieving some relaxation in the group. At the conclusion of one session, the patient fantasied suckling his mother's breast and saw his father glare at him at the side of the bed. He concluded the fantasy by

striking his father. He then launched into the boss as one who, like father, would rob him of his security; that is, of his position as the editor of the agency's monthly publication. After he had expressed considerable resentment toward the boss, he felt that, in the future, he would be able to deal more frankly with him. His relationships did improve, but made for little change in the patient's general tension. The patient later reported at one of the group meetings that the relaxation he obtained by working on his problems in the group had very little carry-over value in his daily life. At this point, the therapist suggested there might be facets in his relationship to his boss, father and brother, as well as perhaps other authoritative figures, that neded further exploration; and possibly there might be factors in the office situation that he was reacting to but had not brought out. The patient, with the help of the group, continued to work on the father and brother transference to the boss, achieving the usual temporary relaxation in so doing, but he continued experiencing the same amount of general tension in his daily life. Subsequently, the patient brought out that he had also been able to relax at home by meditating on the problems which he had discussed in the group, but that the relaxation was still of short duration. The therapist intervened to suggest that, since nothing therapeutic had resulted from his frequent revelations about his boss, father and brother, his relationship to his boss might be a secondary problem, perhaps a red herring which helped him to evade some more important issue. The therapist then suggested that he give the group a minute-to-minute report on what happened at the office during the day. The patient said that he didn't see much point in doing this, but would comply with the request if the therapist felt it might bring out something of value. What follows is his account of what happened at the beginning of his day at the office:

I hate to get at my desk in the morning. I know it's just the beginning of another day of frustration. The guy next to me goes along smoothly with his script-writing;

I struggle and struggle. Sometimes I think I'll ask him to help me with my technique, but that would be admitting that I don't know anything. I think the people I work with think that anyway. I say to myself, "If I could relax, I'd show them."

This statement of the patient opened up the deep-seated problems of his competitiveness with his peers, and his feelings of inferiority as shown by the minute-to-minute, unfavorable comparisons of himself with others. These problems were gone into with the result that he became less defensive about his limitations as a script-writer, and he began to experience occasional days of complete comfort at the office. The favorable therapeutic result which came from this insight into his feeling of competitive inferiority served to highlight the fact that the patient and the group recognized only in retrospect the hidden significance of the patient's persistent talking about his relationship to his boss, father, and brother. His repetitious discussion was an attempt to show the group his apparent superiority in self-analysis, which was his way of unconsciously compensating in the therapeutic group for the real problem of his self-abasive attitude in his work as a script-writer.

A personal experience as an observer in a group will serve as a final illustration relative to the definition of a patient's problem in a group situation.[8]

Self-revelation was used by a patient in this group for a period of several months to encourage self-exposure in other members. One member of the group berated me in private sessions for not being as effective a catalytic agent in individual therapy as this self-exposing group-expeditor. Several months later, the same patient who had berated me, said to the patient who facilitated the group work: "I like what you say, but not the God-like tone you use in saying it. Since you have intimated here that you have given the group only the material you have worked through in your personal sessions with the doctor, I wonder if one of your problems isn't the need to be superior." The patient who was thus assaulted left the group after the meeting when his problem was spitefully defined for him, and he didn't return.

The first of these two illustrations points up two important facts about self-revelation. The first is that self-revelation *per se* can be a matter-of-fact statement, free of distortion and indicative of a real problem. There was no question, for example, about the matter-of-factness of the data given by the patient who worked on his relationship to his boss as the condensed equivalent of his father and brother. The patient's wife, who had known her husband and his family many years prior to their marriage, provided collateral information which amply corroborated the patient's story. The second fact is that the way a problem is approached or worked on can be covertly used for the satisfaction of one's neurotic needs. This was what happened when the patient unwittingly selected a secondary problem which enabled him to exhibit to the group his apparent superiority in self-analysis.

In summary, what is important here is that the therapist and the group need to be aware, not only of "what is being said," but how "what is being said" is used. Is "what is being said" used in the service of a neurotic attitude or manipulation, or is it being used to understand a neurotic trend? One may note again that what the patient initially said was in the service of his need to be superior, which covered over the real problem of his feeling of competitive inferiority in his relationship to his peers.

If the two questions, "What is being said?" and "What normal or neurotic use is made of what is being said?", are kept in mind by the therapists and the patients who do group work, there will be greater likelihood of understanding the significance of each member's communications.

Self-Revelation (Phase II) and Integration

The illustrative material has only covered what happens in a group during the first phase of self-revelation when problems are being defined. In the approach by the group to its problems in the two latter phases of its work, it continues to be of the essence that each individual's material must be con-

stantly reviewed from the standpoint of content, as well as the use that he makes of it. It should be remarked, since no cases will be given to illustrate the second phase of self-revelation and the third phase of integration, that, in these latter stages, the therapist is progressively less active in the group's therapeutic endeavors. His functions have largely come to be taken over by the individual members of the group. It should also be noted that, as the group work progresses toward the changing objectives of the second and third phases, the actual working through of the interpersonal ramifications of each group member's problems is facilitated by the normal and neurotic interactions of the group members and the increase in each individual's awareness of the meaning of these interactions.

Advantages of Group Psychotherapy[6]

The question might be raised at this point concerning what happens to a patient in analytic group psychotherapy that can't be matched in individual psychotherapy. In group psychotherapy, the patient soon gets over his feelings of isolation and uniqueness once he sees that he has problems in common with others. As a corollary, he takes less time to overcome his anxiety about sharing his problems with and appreciating the difficulties of others. He finds it easier to transfer what he learns from the therapeutic group into his current family, social, and work groups. The therapeutic group is life-like, in that it enables a person to work in a group on problems that had their origin in an antecedent group setting, be that setting the family, the playground, the classroom, the Sunday school, or the job. The life-likeness and significance of the group situation cannot be overstated. For example:

A patient compulsively used the tedious and repetitive descriptions of his lack of psychosexual and social development to make the group listen to him for prolonged periods. In making them listen, he realized, for the first time, that he had the courage to act out his defiance, which he had been too frightened to attempt at home. The group helped him to recognize his acting out and

suggested that he didn't have to seduce them with psychosexual material to get their attention, inasmuch as he would gain more respect from them if he dared to be himself and to express directly his need for attention.

It should not be inferred from what has been said that group psychotherapy for out-patients is an entirely favorable situation once the group has begun its work. It is not uncommon for group psychotherapy to be traumatic, and, as a result, a not insignificant number of patients drop out or are driven out by the group. The example of the group-expediting patient who did not return to the group after his need to be superior was spitefully spotted by another patient, is an excellent demonstration of what can happen, especially when a useful insight is given in a destructive spirit.

Group Psychotherapy for Psychotics

Let us turn now to the subject of group psychotherapy with psychotics and see what has been done and what possibly can be done for them. What immediately follows concerns work with hospitalized schizophrenics, and is largely extracted from Dr. Jerome Frank's paper, "Group Psychotherapy with Chronic Hospitalized Schizophrenics."[9] This paper is an abbreviated report on the phase of group therapy research on hospitalized schizophrenics which was conducted by Dr. Florence Powdermaker and Dr. Jerome Frank under the auspices of the United States Veterans Administration.

Group work with schizophrenics began in a planned way about 1920. Since then, "many forms of group therapy have been tried with institutionalized schizophrenics, including educational, psychodramatic, and analytically oriented approaches. Despite wide differences in philosophy and method, all who have worked in this field agree that the patients can be helped by group treatment."[10]

In the research to date on the optimal composition of therapeutic groups of chronic schizophrenic patients, no final formulations have been reached.

An important finding in the study of psychotic groups was: "In those groups in which therapy was

most effective, patients who improved markedly tended to do so in the first six to eight months."[11]

Two different philosophies emerged in the course of the Veterans Administration project about what constituted the significant factor that made for therapeutic change in the schizophrenics. "One philosophy regarded the group experience as the principal therapeutic agent. From this standpoint, the major goal of therapy was to strengthen the patients' grip on social reality and their capacity to communicate with others through relationships with others in the group. The doctor's role was conceived primarily as that of promoting group interaction and helping patients to understand what they were doing with and to each other. His focus was on the group, rather than on individual patients. This approach tends to work with the healthy rather than the sick parts of the patient's personality."[12]

"The other viewpoint held that the main therapeutic agent was the closeness and intensity of the patient's relationship to the doctor. The doctor who operated most consistently according to this principle, tried to bind each patient to him as closely as possible, in the process automatically fostering intense rivalries among the patients for his attention. He concentrated on the individual patient, rather than the group, and tried to demonstrate that he could accept, without anxiety, the full force of the intense emotions thus released. He hoped that, through this experience, the patient would gain increased ability to handle the feelings which he feared in himself, and so gain greater self-confidence. As this occurred and his anxieties diminished, his distortions of reality should likewise diminish and his condition improve. This approach, instead of minimizing the psychotic aspects of patients' attitudes toward others, encouraged their fullest expression."[13]

"Our experiences," concludes Dr. Frank, "allow no decision as to whether the method of working primarily with the group or working primarily with individual patients is better. (Both) groups . . . did

rather well. It began to appear that perhaps the chief factors in the success of the group were certain attributes of the doctor's personal approach . . . Those groups did relatively well in which the doctor exhibited firm, sensitive leadership and clearly structured the situation for the patients. Those groups did poorly in which the doctor adopted a *laissez faire* attitude, was apparently obtuse as to what was going on, was obviously insecure, or was inconsistent in his behavior. This leads me to wonder whether the particular technique used in the treatment of schizophrenics may not be largely irrelevant. Perhaps what really matters is the general attitude of the doctor. This study, in common with all others on therapy of schizophrenics, has made very apparent their great sensitivity to certain attitudes of those about them, coupled with confused, distorted social perceptions and fear of their own emotions. As a result, they become involved in a welter of contradictory, confused, frightening feelings toward anyone who tries to help them. The group situation seems to facilitate overt expression of these feelings, as well as others, so that it makes great demands on the perspicacity, capacity for acceptance, and moral courage of any doctor who attempts to deal with them. If he vacillates or lets things slide, he leaves the patients confused, contemptuous of him, and more anxious than before. If he structures the situation clearly and firmly, he gives them a framework in which they can function with relative comfort, and by his steadiness, he may be able to help them work through to some relatively satisfying solution of their conflicts. Whether or not the doctor can help these patients may depend chiefly on whether or not he can win their confidence, and this may be largely a matter of his ability to appear as a strong, consistent, reliable leader, sensitive to the patients' feelings and able to accept them, while, at the same time, being prepared to cope with them firmly if they endanger himself or the group."[14]

Dr. Frank's significant statement that the attitude

of the therapist matters more than his technique, is happily confirmed in an unpublished report on more or less structured group psychotherapy projects conducted at a Veterans Administration Hospital by two residents who were relatively untutored in the specialized techniques of psychotherapy, but who possessed the initiative born of the conviction that something could be done about improving the morale of the patients receiving deep coma insulin. The collecting of the data and the writing of the report was considered, at the outset, a chore to be disposed of as soon as possible. However, as data were gathered, the reporter came to feel he was being let in on a secret of some importance, the secret of resourcefulness and creativity in ordinary people who have a vision. The two residents' simple but transforming idea is reflected in the excerpts from the report:

The reason for giving deep coma insulin patients adjunctive group psychotherapy was that all of them have considerable apprehension about the insulin treatment, and it was felt that their general tension could be lessened and social recovery promoted if each individual's specific fears and questions about the treatment could be aired openly in a group setting. The working philosophy of the two therapists has been that the weekly, two-hour group sessions could not only help to allay anxiety about the insulin program, but, in addition, an attempt could be made to handle one of the basic difficulties of psychotics, namely, their intense feeling of rejection. The latter objective could be striven for by pointing up to the group, when the opportunity presented itself, that each person in the group had been picked for insulin treatment because his history indicated that he had a favorable prognosis, that each person was carefully watched by the attending personnel before, during, and after the stage of coma, and that one of the principal satisfactions the personnel got out of their work was in seeing persons who were getting treatment improve.

The method used in conducting the group sessions has been to have the patients assemble in the recreation room, where the therapist would open the meeting by simply asking the group what they would like to talk about. It was observed that the less withdrawn individuals would take the initiative in bringing up their anx-

ious feelings experienced on awakening from coma. They would also raise questions about the need for and the value of insulin therapy, the length of treatment, and so on. A discussion of these matters was brought up in the first several sessions by each group, and gradually, as the group discussion caught on, many of the more withdrawn members of the group became active participants in the discussion. In order to indicate that any topic could be brought up for discussion, the therapist invited comments as to what the group thought of the hospital, the therapist, the ward personnel, and the food. Comments were also invited as to whether they were getting better or worse as the result of treatment. At the stage when the groups verbalized rather freely, encouragement was given to discuss personal situational difficulties that existed prior to their coming to the hospital. Psychodrama was used by one of the therapists when the real personal problems were brought out into the open, and it was felt by the therapist that, with trained personnel to assist in the psychodramatic situations, a post-insulin psychodramatic working through of some of the real problems of the patients might be extremely profitable in consolidating the gains from the insulin treatment and the adjunctive group therapy sessions. The other therapist did not use psychodrama, but introduced the fun factor into his sessions with the group. He had patients demonstrate card tricks and then explain them to the group; he also had the group draw a simple object, such as a chair, and then had individuals in the group explain all that they could about their particular drawing. Patients who played musical instruments were sought out and invited to play solo or group numbers. In sessions where considerable complaining occurred about the hospital, the personnel, and the insulin treatment, a recording was made and played back to the group, with amused and desensitization effects on the part of those who did the complaining.

Each therapist felt that, as a result of group work, specific anxieties of patients about insulin treatment were allayed, the interpersonal relating of the patients to each other increased, and in general, a greater openness in discussing personal problems with the therapist and the group was brought about.

Since the commencement of group work, the insulin patients have been able to identify themselves as individuals selected for special treatment and as members of a special group. The new patients, as a whole, have shown less resistance to treatment as a result of the more optimistic attitude that prevails among patients already

receiving treatment. The ward personnel not only remarked frequently about the improvement in the patient's attitudes, but they, themselves, became more hopeful about, and interested in, the patients.

Two summary remarks emerge from Dr. Frank's paper and the work just referred to by the two residents: (1) there is nothing final about the work practices or techniques in the group psychotherapy of neurotics or psychotics at this date; (2) what seems to be more or less final is the indispensability of what might be called a comprehensive attitude on the part of the group therapist: an attitude that enables him to feel "at home" with patients, and, in addition, allows his own resourcefulness to come into full play in order that he can give to patients in his own peculiar creative way.

Thus far, the effective factors which make for change in people who experience the group process have been presented. It is thought that what has been pointed up, especially in the analytically oriented type of group therapy, has application, not alone to group psychotherapy as conducted by psychiatrists, but for all forms of group work.

Essential Factors

To recapitulate: The essential factors that permit us to be agents for effecting changes in individuals or groups, is our personal attitude toward ourselves and others. To know what effect we are having, we have to know what it is that basically motivates us. If there is a need, for example, to get a certain kind of result for our own sake in our work with groups, we will fail to see the need of the group and the individuals in it. If we understand, however, how our own needs get in the way of the needs of the group we serve, we shall be open to what the group communicates, even though we may not understand the full significance of its communications. To maximize the understanding of the communications of the group, it is important that we have as two of our basic tools: a sound knowledge of and a keen feeling about the psychodynamic forces that make for health and illness, and the verbal and nonverbal

means that are used to give expression to our feelings of health or illness. Is the implication of what has just been said that before we can be effective conductors of group work, we first have to be a psychiatrist? Indeed not. Many patients stage their return to health by way of the experiences they have in their group, religious, or educational activities, conducted by a religious person or an educator, and not through the medium of their exchange in individual or group sessions with a psychiatrist. Group psychotherapy, as conducted by a psychiatrist, is only one of many media for helping a patient recover some or all of his sense of identity as a social person. To return to the question of a moment ago: In many instances, one will do keen and effective work with groups by virtue of a health that resides in his attitude toward people, sick or well. Is it not also a practical and worthwhile objective for those working in groups to point in the general direction of becoming experts in communication in order to to maximize their ability to understand and serve, through their special medium, the many people or patients whom other group and individual approaches fail to reach?

The therapist's attitude toward and his understanding of what a person is trying to communicate have been stressed because these are the basic agents for effecting changes in individuals in groups. One of the main values of group work is that what is learned in a group has greater and more ready transfer value to varied situations, such as the family, the job, and other social groups to which the individual is attempting to return as a functioning member, or in which he is attempting to improve his functioning.

The religious leader, the educator, or group worker who cares for and shares with those in the groups with whom he works and who, in addition, has an expert appreciation of what is being communicated to him by means of verbal or nonverbal signals, can give answer in some measure to the basic need of persons: their need to be meaningful emotional and spiritual entities in their own estimation, and in relationship to their fellowmen.

Bibliography

1. Burton, W. N.: The Guidance of Learning Activities. New York, Appleton-Century-Crofts, Inc., 1952.
2. Thomas, G. W.: Group Psychotherapy. A Review of the Recent Literature. Psychosomatic Medicine, 5, 1943.
3. Klapman, J. W.: Group Psychotherapy, Theory and Practice. New York, Grune and Stratton, 1946.
4. Moreno, J. L.: Psychodrama. New York, Beacon House, 1946.
5. Powdermaker, F., and Frank, J. D.: Group Psychotherapy: Studies in Methodology of Research and Therapy. Cambridge, Harvard University Press, 1953.
6. Coffey, H., Freedman, M., et al.: Community Service and Social Research—Group Psychotherapy in a Church Program. Journal of Social Issues, *6*:1, 1950.
7. McDanald, E. C.: The Masking Function of Self-Revelation in Group Therapy. International Journal of Group Psychotherapy, *1*:1, 1951.
8. Ibid.
9. Frank, J. D.: Group Psychotherapy with Chronic Hospitalized Schizophrenics, in Brody, E. B., and Redlich, F. C., Psychotherapy with Schizophrenics. New York, International Universities Press, 1952.
10. Ibid.
11. Ibid.
12. Ibid.
13. Ibid.
14. Ibid.